सही उम्र में शादी
सोच कर बच्चे

ज़िम्मेदारी निभाओ
प्लान बनाओ

Sterilization Certificate

Hospital Registration No. (IPD/OPD) ______________

1. This is to certify that Smt/ Shri.. S/O; W/O Shri .... working as .... residing at .... has undergone Minilap Tubectomy – (Interval/Post-Partum/Post Abortion/Concurrent with other procedures)//Laparoscopic Tubal Occulsion (Interval/Post Abortion/Concurrent with other surgeries)/Vasectomy Conventional/ NSV) in this facility/hospital ....(Name of facility/Hospital) on .... by Dr...

For Female Sterilization:

2. She has resumed her menstrual Cycle (LMP_____) or she has not resumed her menses within the month of sterilization but pregnancy test is negative.

For Male Sterilization:

3. His semen examination undertaken on (Date)________________ revealed no sperm (azoospermia)

**Strike out whichever is not applicable*

She/ He is therefore certified to be sterile

Signature of Medical Officer I/c

Name....................................

Date ....

Seal ....

Note: Client should acknowledge 'received' on the duplicate copy before receiving the original copy. The duplicate to be maintained as a record in the facility as per state norms.

Department of Health & Family Welfare, U.T., Chandigarh.